EFFECTIVENESS AND EFFICIENCY IN HOSPITAL MANAGEMENT AND THE INTERDEPENDENCE OF HEALTH SERVICES*

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THE main purposes of my foundation are the regional coordination as well as the improvement of hospital and associated medical services.

In my experience, therefore, the hospital, as a completely independent species and an isolated management entity, is well on the way to extinction. It would be ridiculous, of course, to suggest that the most expensive institution concerned with medical care is moribund. But in relation to what is required to tend to the health of the mass of the people in this day and age, and to the objectives of medical care as they are beginning to be refined, the hospital cannot exist in isolation from the community; and few if any hospitals can be effective as health service institutions if they seek to do so.

There is, however, a paradox here, for many of the greater hospitals are justly proud of the belief that so far as effectiveness is concerned they are at the highest level ever of their operation; it is certainly true that if there is disquiet and anxiety about their financial states such a problem is by no means a new one; the ill will always pour out their treasure on earth to be well again; and, since those charitably inclined are likely to have a soft spot for institutions which are concerned with the care of the sick and the alleviation of illness, it is a fair guess that those concerned with the management of hospitals have some basis for being optimistic about their financial viability in the long run. There are, however, strong indications that the management objectives of health service organizations are in a course of change to a degree of complexity which calls for special consideration now in advance of their achievement.

*Presented as part of the 1972 Health Facility Conference of the New York Academy of Medicine, *The Hospital as a Community Facility,* held at the Academy April 27 and 28, 1972.

When one begins to treat the hospital as a community facility and so broaden the base of its operation and appeal one introduces a variant which is strongly catalytic and not easily controllable. The inevitable erosion of independence has appreciable effects, particularly on the nature of the hospital's relation with other extramural bodies with which it is associated in the welfare of the sick, as well as on its internal management. In particular the accountability factor takes on new proportions and the more formalized relation with the shadowy entity called "the community" hides a lot of mantrips, and not a few satraps emerge, zealous to a degree. Accountability is in essence not exactly a new concept: but in today's complex society it is fast acquiring strengths and sometimes far-reaching effects which cannot always be foreseen when desirable social reforms are first mooted.

Webster's Third New International Dictionary defines "accountable" as "answerable." If this meaning is applied in the context of health service institutions it is interesting to probe the main constituent elements of this answerability; for the shape of the mechanism of management and structure designed to achieve optimum efficiency depends on how one interprets the results. One thing certain is that the efficiency and effectiveness of the institution operating as a community facility depend on factors of a character not presently stressed in the traditional concepts of the management of hospitals, if one is to judge from a comparative study of the literature or what one knows of the general educational strategy.

The real point is that it is doubtful today in the Western World whether, in viewing the management task of any facility designed to serve a population, we can separate the business of Caesar from the conceivably more godly activity of medical practice; and it is astonishing that we still pretend that we can. This is because of the cultural maze which is a special feature of medical care. Thirty, 20, perhaps even 10 years ago, it was possible to talk sincerely, if a little glibly, about a patient-doctor relation which suggested a simple one-to-one factor. This reflected the basic culture acquired not only in the medical school but which reigned in society as a whole. It was perhaps the main operative belief governing human behavior in seeking skilled help in sickness; but in spite of all the evidence that it is rarely true, the idea still remains not just as a hangover but as a strongly held motivating philosophy, influencing events if only by the setting up of taboos. Yet who can

deny now that there are many other factors extant which must cause one to examine very closely, and greatly qualify, the deductions often drawn from or implied in such a one-to-one relation, not only in connection with a fairly well-defined system of medical care arrangements such as the National Health Service in Britain but also with the forms of organization applicable in the United States.

The major thing that has to be recognized is that while the patient may still be unique as an individual, no one concerned with diagnosis or therapy in the hospital is an island himself; nor is the hospital an island either. The complexity of diagnosis and treatment in the case of the individual and the unique complexity of the internal and external relations of the hospital indicate that all these apparent islands are joined together by reefs and shoals, the charting of which is more than an intriguing exercise, but to my mind essential to where we are in medical care and to ultimate progress.

The use of scientific methods in medicine and the proliferation of professions involved need no stress to explode the one-to-one idea, but it is the amazing complexity of the actual organization required in the social context of today which bamboozles most of us in the West. Nor does it seem to matter much in the long run how the facility is financed, whether by personal insurance, government subsidy, or pluralistic sources. When the idea of a middleman or body between the patient and the doctor is accepted, a special range of extra accountabilities enters into the contract. The thesis of accountability can be applied to cover a multitude of operations—insisted on for the best of professional motives as well as for the protection of the patient and the community. Indeed, the range and magnitude of the resultant problems creates a demand for special help. Corporation men with just such skills take over, and again a fresh series of internal accountability requirements are born.

In the case of hospitals the emphasis hitherto has been on the setting up of the apparatus of business management. Frequently the main objective is that the institution must balance its books. Mr. Micawber's dictum must hold. But if the main objectives to which the hospital is subject become something different, if they are widened to include the setting of standards of care for the individuals covered in the community, and if the hospital becomes accountable for standards and performance, terms used freely in efficiency studies, what then? The

effects I suggest are soon likely to go beyond universal irritation with business jargon. Averages, norms, and deviations from the norm may have had a tendency to start special enquiries in all directions in the past; it is even more likely that they will do so in the future when the question of performance becomes a key issue as it is bound to do if the doctrine of accountability is applied logically. It is undeniable that there is increasing public interest in the outcome of medical care and that the need for some sort of ongoing review is being voiced. It may be of some comfort that at the moment this is something for the medical profession itself, but for how long? Peer review is not only another nail in the coffin of the special doctor-patient-relation idea, substituting group for individual standards, but it seems bound ultimately to take heed of the basic epidemiological concept of the "population as the patient," which no management group can ignore: even if it is a fact that despite the billions of words and phrases spent in pursuit of quality-of-care measurement, the criteria so far developed for judgment is of indifferent quality for effective management use.

Already questions are being asked about performance related to efficiency. Last month the trust for which I work published a book by Professor A. L. Cochrane which I believe to be a significant landmark. In it Professor Cochrane, who is a distinguished epidemiologist, made a series of observations which called into question certain practices in medicine which over the years have been clothed with the authority of science but which now, if we are to look at the efficiency and effectiveness of performance, clearly need to be reviewed. He made a powerful case for a more systematized use of randomised control trials, principally for the effectiveness of treatment but, be it noted, also for diagnosis. But it is especially interesting in relation to the question of improved efficiency that as a direct result there already has been in Britain a great deal of serious public comment to the effect that if we are to move toward a better organized health service system, should we not also be looking at effectiveness and efficiency in clinical functions as part of the drive for better management?

The thesis of the need for reviewing practice is not exactly new; indeed the Nuffield Provincial Hospitals Trust two or three years ago published a collection of papers titled *Screening in Medical Care* which reviewed the scientific evidence to support a number of screening procedures in common use. We commissioned these critical studies as part

of an exploration of prevention in an effort to get beyond the cliché that the attractive policy of prevention has become.

Of course the search for prevention is a bit like that for the philosopher's stone; but a large part of it stems from the belief that there is a high level of certainty about both diagnosis and successful treatment. This hypothesis is barely justified, however; as Dr. Franz J. Ingelfinger has recently pointed out in the *New England Journal of Medicine*, the failure on the part of the medical profession to acknowledge publicly the opposite: i.e., that a fairly substantial degree of uncertainty of diagnosis and of the results of treatment has had most unfortunate results in the widest political sense. To my mind this sense includes the effect on management with its pursuit of efficiency along traditional lines, for with the present assumptions about the science of medicine and the effectiveness of medical care this is too often equated with the need for high capitalization; pressures are created for the greater use of technology, which is not always merited.

The confusion is due of course to the fact that it is scientific technology which is at a high-water mark. But the assumption that medicine itself in its effects is more scientific than it is, is a little suspect. The over-all effect, however, is only too evident. It has stimulated demand for treatment and care, and involved all institutions concerned with the diagnosis and treatment of disease (including the vast research organizations which are a natural concomitant) in greater and ever greater expense as the technology of measurement as applied to medicine has grown. This has meant that the cost of medical treatment has soared to the extent that on one pretext or another governments have had to step in financially. This bears the seeds of political conflict (in the broadest sense) in the ultrasensitive area of social policy, for no government can afford *not* to set up a mechanism for accountability. In some societies with cultures antipathetic to state interference this is seen to pose great threats to professional freedom. To my mind what it poses above all is a need to get clear in our minds what we can hope to achieve by such mechanisms and the attempts to make them efficient —and what is being surrendered. What is truth, what myth?

Indeed the concept of the hospital as a community facility is one which itself needs special analysis. I suspect that one can only generalize about it to a very limited extent. There cannot be a standard community. Variation in size as well as social, economic, and cultural

characteristics defeat simple policies. In relation to epidemics, we recognize that the community has a necessary identity—and that occasionally it must exercise power to protect the majority—but otherwise in medical care is it necessary, for example, to have a community in relation to the establishment of standards?

In Britain at the moment, as part of a drive for greater efficiency in management, a concept is being developed in which the key person is someone called the "community physician," whose function seems to be all things to all men. Sometimes he seems to be an administrator who has had some medical training; sometimes he is seen as an epidemiologist whose function is to study diseases of populations, and will propose as part of the management team arrangements for their entertainment and treatment. The one common factor, however, is that he is supposed to act for the community. It may be seen as a public health activity with a new look.

However, as soon as one poses questions of the health of "populations" one sees, especially in our present society with its special accountability to government, that problems which were of only minor effect at earlier stages in our social order now are becoming much larger. It is evident in the case of crippling epidemics that the best interests of the population as a whole might indeed be against the interests of several individuals within it. But now, with so many other parties' interest in medical care, sometimes the interests of individuals or groups may clash with that of society as a whole. Accountability nowadays is a complex taskmaster with prospects of acquiring alarming hang-ups which have to be kept under observation and in check.

Indeed, when the management base is broadened to take in the community, and this is decided as national policy for a mixture of reasons, the problem of distinguishing absolute truths is accentuated. It has been said in relation to the detachment called for in the purest form of research: "The observation of nature as opposed to the management of society, requires a receptive passivity as opposed to a community activity, and a freedom from ill-conceived theories in contrast to an attachment to a set of social convictions."

No amount of detailed observation of the nature of man will by itself be allowed to be a substitute for community action in relation to medical care; and since we are all willy-nilly nowadays concerned very much with the management of our societies, the direct attachment

to a set of social convictions is clearly a major force in shaping the nature of the organizations we bring into being and the approach to managing them. If we must free ourselves from the ill-conceived theories which seem to abound in medical care, we shall have to accelerate the drive to examine, more critically than has ever been dreamt of before, every aspect of care and treatment, and this is a difficult judgment at the moment.

The social convictions in relation to medical care have become fairly clear universally. In the United States the outline has been etched more sharply each year; this year, indeed, your president has accepted a formula in his national health strategy that not only must the whole population have access to the best standards of medical care but that there must be an end to any "racial, economic, social or geographic barriers which may prevent adequate health protection." This is a set of social convictions from which, I believe, much will flow. It is a prediction of a national policy and therefore a precedent on which much can be founded and which will inevitably bring in train many accountable activities. In Britain we have had a set of social convictions in relation to medical care which have been in legislative effect for 25 years, and we are still trying to sort out misconceptions about it in relation to accountability and freedom. It seems to me our experience poses the need for looking ahead beyond our present distractions (on both sides of the Atlantic) with finding organizational solutions with inadequate consideration of the philosophical base. If we talk of efficiency I doubt if it is possible to separate totally something called the "business side" from the objectives of the community-based health service organization.

This brings me back to the over-all title of this conference, *The Hospital as a Community Facility*, and the immense scope of the task in management faced by hospitals.

It seems to me that in relating all these issues to the theme of improved management in the future the question first arises about their relevance to the aspirations and operations of the community. This leads directly to the question of the objectives of medical care as a community utility.

Contrary to common assumption, the lessons of history indicate that, for all of the intellectual challenge and the drama highlighted by the problems it has presented, the treatment of acute diseases of the

individual has not been the major contributing factor in advances achieved in the health of populations. Nor is such treatment any longer the most urgent problem in the delivery of health services. Nor, for that matter, is the major problem of prevention, that siren which appeals to so many of us when we are discouraged by the crushing burdens of medical care, although it is certainly arguable that the treatment of acute episodes of illness can be very important as a means of preventing or postponing the onset of chronic degenerative disease later. Rather, the so-called residual problems, which generally are more concerned with care-and-maintenance medicine than with cure—such as congenital handicap, mental handicap, geriatrics, and mental illness—probably constitute the most dominant problems facing any society concerned with organizing effective health services. If we really are concerned with the organization of health services as a whole, management cannot avoid having to decide how much effort should go into acute medical care, including intervention to postpone, and how much into maintenance care. Even the question of prophylaxis is debatable on the issue of urgency, for it is not difficult for hard-pressed management to see the solution to the problem as long-term—what ought to go into prevention in order to get a reasonable return on the investment. Indeed, health services and the sociomedical services are clearly part of welfare services; and, if this is so, does this not introduce a different and more challenging concept to management?

Those responsible for the management of community facilities have thus a Herculean task to meet this challenge effectively and efficiently. If they had to constitute a completely new service the aim would be difficult enough—to fit the resources to meet the major problems. But the existing rights and privileges in a specialized sector of society, caste- and professionally ridden, prescribes the freedom to manage.

The briefs to the constituent panels are eloquent enough in their challenges. We all know that the needs of hospital service continually reflect the demands made on behalf of hospital developments and are never satisfied; and this fact, fueled by the belief in the effectiveness of technology, is reflected in soaring costs. At the same time it is demonstrable that the facts throw into doubt the accepted cultural assumption drawn from the one-to-one relation between patient and doctor and between specialization and proliferating professionalism in medicine. The competition for relatively scarce resources demands

a balanced consensus for action, the mechanism for which has to be provided and governed by some acceptable doctrine of accountability. It is equally true that if medical care services are to be organized on an area or a regional basis the rights and privileges of the individual institutions can no longer be sacrosanct. The acceptance of the principle of interdependence has a long chain of causation if one is seeking efficiency. Above all, if the social conviction, followed by political action is that there should be a high standard of *hospital* care available to all, there is no question but that the highest level in physical and professional terms will be the target of the efficient manager even without the inevitable push from those people who have hitherto had no or limited access to high-quality care.

Pity the management that has then to translate political determinism to sensible operation and show improvement! But even more problems loom on the horizon. If we are really going to try to have efficiency at a community level—and on the doctrine of accountability, management will eventually be prodded to do so from all directions: government, professions, etc.—what is the development of epidemiological techniques and the improvement of the quality of information that is being demanded going to tell about performance? What kind of driving force will this developing speciality, the new-look public health, prove to be? This is the key question that will have to be debated far more than hitherto, for special pressures are accumulating.

Because of the inevitability of scrutiny there is certainly a need for a better ordered study of the effects of place, duration, and method of treatment; in any community health service it is not difficult to foresee that the controlled clinical trial is likely to be developed in the future for assessing therapy. The field is almost certain to become a Klondike for the questing sociomedical investigator in the future, and also for management.

Indeed it has already been suggested in Britain recently at a sensible, authoritative level that there are two levels of review on which epidemiological investigations should be made which might be the basis for changes in organization and methods at the community level. The first will cover what is happening in the population in morbidity and mortality; the second, the provision of and results of treatment, and preventive steps, which presumes the setting in train of carefully planned, controlled trials. An over-all strategy to achieve this is prob-

ably necessary for the improvement of the quality of care in the community, and should be conceived as part of the management approach.

My thesis, therefore, is that the question of improved management extends well beyond the traditional organizational questions into the field of quality itself. The influence governing directions will be both external and internal: external because of the spread of accountability at government and community level, internal because of the perceived need for the purposes of accountability. The external pressures will have the full weight and authority of the community behind them; somehow the organization itself will have to have a sensitive means of reviewing matters in which the community as a whole has an interest; this will include the effectiveness of care.

I hasten to say that I am not trying to raise bogeys to alarm the timid or to point to the dangers inherent in change which are likely to threaten individual and professional freedoms. I do think, however, that it is extremely important, if we believe in a balanced democracy and are skeptical of the ability of a stifling bureaucracy to operate the system, that we should try to ensure that these issues be discussed sensibly and without destructive heat.

As a foundation executive, I am, of course, a professional optimist and therefore feel that all things are possible; but sometimes I feel with Arthur Koestler, in his recent book, *The Roots of Coincidence*, that Sir James Jeans had a point when he questioned whether the universe was a system, that perhaps it was only an idea.

In the case of health services, perhaps it is the *idea* that is important. To strive for systems based on a set of universal principles too hastily conceived and then to strain to make the mechanisms efficient without an assessment of total gain and loss is asking for something whose evident impossibility hinders, if it does not actually destroy, its own development.

What we need above all is to develop a theory of management with a strong enough philosophical base to enable us to avoid the undesirable restrictions to individual and professional freedom which are death to dynamism.

We also need to make the governing principles flexible enough to be alien to the important metaphysical considerations central to medical care but at the same time not to be escape hatches for professional passivity.

I believe, therefore, that it would be a folly for *clinicians* to opt out of the management structure. I go further and suggest that the role of the aristocrats of medical care, normally to be found in hospitals, must extend into the community in a more subtle and sensitive way, so that community involvement does not merely mean the provision of particular services either for cure or care, but includes, as well, educational efforts in health to teach the population how to get the best out of services reasonably. The end result of this can clearly be only a much more aware society.

If this appears to be an overindulgence in idealism it is certainly not meant to be such, but rather a vision of a desirable objective.

It also seems to me to be unrealistic to assume that the questions I have been discussing are applicable only in a formalized national service such as exists in the United Kingdom. It seems inevitable, with recent developments—especially the drive for public entities like HMOs—and with the particular accent on management and its effectiveness in the United States, that no matter how health services are ordered, these are questions that those concerned with providing services are bound eventually to get round to asking—and can be justified in so doing, if one assumes that someone or some group eventually is going to be made *accountable*. The ever-increasing share of resources deriving from public funds in the health area will be its powerful motivation.

Fundamental to this theory is the need for a mechanism or mechanisms for independent questioning. It is doubtful if most of the major institutions concerned, even the universities, have the means to do this in the over-all systematic way that is needed. Yet the adequate education of the entire range of professionals needed for effective health services can be founded only on such a base of questioning.

This represents a gap which must be filled, but this, like the future of freedom, demands a judgment of its own. The gathering of free men and of unfettered minds of all disciplines to review and monitor the structures and inhibitions of such structures as we must have for the delivery of medical care is not just an intellectual luxury but an absolute necessity for democracy.

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